PEEHIP New Enroll/Status Chg
(07/14)
6U

Check One:
☐ Active Member
☐ Retired Member

NEW ENROLLMENT AND STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
You may submit information online at **https://mso.rsa-al.gov**

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security # or PID	First Name	Middle Initial	Last Name	Date of Birth	Sex
				____/____/____	☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed — Date Married: ____/____/____

Is your spouse employed? ☐ Yes ☐ No — Does your spouse have other health insurance coverage? ☐ Yes ☐ No

Mailing Address	City	State	ZIP Code

Is this a change of address?	Home Phone	Cell Phone	Work Phone
☐ Yes ☐ No	_____-_____-_____	_____-_____-_____	_____-_____-_____

Employer/School System	Date of Employment	Email Address
	____/____/____	

Have you or your spouse used tobacco products within the last 12 months?*
This information is required for enrollment.

Member	Spouse
☐ Yes ☐ No	☐ Yes ☐ No

PEEHIP Coverage Information

(You will be billed for prorata premiums or premiums that are not deducted from your payroll or retirement check.)

Section A. New Enrollment

Basic Hospital/Medical
(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)

Coverage Type: (*Select only <u>one</u> of the three plans*)
☐ PEEHIP Hospital/Medical
☐ VIVA Health Plan (HMO) (Primary Care Physician _____)
☐ PEEHIP Hospital/Medical Supplemental**(*Secondary Medical)*
***Complete Primary Insurance Information in Section D if choosing this plan. This plan is not a Medicare supplement & differs from Optional Plans.*
☐ Single or ☐ Family *(complete Section C)*

Requested Effective Date ____/____/____ ***(required)***

Optional Coverage Plans
(*administered by Southland National)*

Note: *Optional plans must be all Single or all Family*
Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision
☐ Single or ☐ Family *(complete Section C)*
These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).

Requested Effective Date ____/____/____ ***(required)***

Section B. PEEHIP Coverage Information

Coverage Type: (Only check boxes requiring a change)	**PEEHIP Hosp/Med**	****PEEHIP Supplemental**	**VIVA HMO**	**Cancer**	**Dental**	**Indemnity**	**Vision**
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed in Section C to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed in Section C from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ ***(required)***

Reason for Status Change(s) *(check all that apply)*
Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred (*) items.

Date change occurred ***(Required)*** ____/____/____

☐ Open Enrollment – **Change effective October 1st**
☐ Adoption of a child* *(need adoption papers)*
☐ Birth of a child* *(need birth certificate)*
☐ Death of spouse/dependent* *(need death certificate)*
☐ Dependent loss of coverage* *(need proof of loss of coverage)*
☐ Divorce/Annulment/Legal Separation* *(need divorce decree)*
☐ FMLA/LOA
☐ Legal custody of a child* *(need legal custody papers)*
☐ Marriage* *(need marriage certificate & add'l proof of marriage)*
☐ Marriage of dependent child
☐ Termination of spouse/dependent employment*
☐ Commencement of spouse/dependent employment*
☐ Medicare/Medicaid entitlement* *(need copy of card)*

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. ***QLE changes must be submitted within 45 days of the QLE.***

Section C. Dependent Information *(only required for family coverage)*

Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Appropriate eligibility documents are required for all dependents: All children – birth certificates; spouses – marriage certificate & additional current marriage document; adopted children – certificate of adoption or papers from adoption agency showing intent to adopt; step children – also required is the marriage certificate showing member's spouse is married to member; foster and other children – also required is the placement authorization signed by a judge or final court order with judge's signature and seal. *(See handbook for more detail.)*

Name of Dependent *(First, Middle, Last)*	**Social Security #**	**Date of Birth**	**Relation to Subscriber**	**Sex**	**Handicapped**
			☐ Husband ☐ Wife	☐ M ☐ F	N/A
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No

Section D. Primary Insurance Information** *(Must be completed if choosing PEEHIP Hospital/Medical Supplemental)*

Name of Insurance Company	Phone Number	Contract/Policy #	Effective Date of Coverage
	_____-_____-_____		_____/_____/_____

Section E. Other Health Insurance Information *(Must be completed for enrollment)*

Are you, your spouse, or dependent children covered under any other Hospital, Medical, Dental, or Vision plan(s)? ☐ Yes* ☐ No

*If you answered yes, you must complete a separate COORDINATION OF BENEFITS (COB) form, available at www.rsa-al.gov.

Section F. Retiree Other Employer Information *(Must be completed if you retired after September 30, 2005)*

Are you a retiree and employed by another employer? ☐ Yes* ☐ No

*If you answered yes and you retired after September 30, 2005, and became employed by another employer, you must complete a separate RETIREE EMPLOYMENT VERIFICATION form available at www.rsa-al.gov.

Section G. Medicare Information

Are you or your covered dependent(s) eligible for Medicare? ☐ Yes* ☐ No

*If you answered yes, you must complete this section and provide a copy of the Medicare card(s) to PEEHIP before your monthly retiree premium can be reduced. **Note: As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have adequate coverage with PEEHIP.** If you fail to timely enroll in Part A and B, you will have a lapse in coverage if your effective date for Part A and B is after your date of retirement. You are financially liable for medical costs incurred as PEEHIP will only pay 20% of the Medicare allowable fees.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D**-Effective:_____/_____/_____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D**-Effective:_____/_____/_____

***If you are enrolled in another Medicare Part D plan (other than PEEHIP's Medicare GenerationRx), you are not eligible for the PEEHIP prescription drug plan coverage.*

Section H. PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Member Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the front of this form.